

Welcome to Today's Meeting!

- Housekeeping reminders:
 - ▣ Please **mute** yourself when **not** speaking
 - ▣ The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
 - ▣ We encourage you to keep your video on throughout the event
 - ▣ Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at MAPHealthEquity@qualityforum.org



Measure Applications Partnership (MAP)

Health Equity Advisory Group Review Web Meeting

December 9, 2021

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003 Option Year 3.

Agenda

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- CMS Opening Remarks
- Overview of Pre-Rulemaking Approach
- Discuss Measures Under Consideration (MUC) List
 - Clinician Programs
 - Hospital Programs
 - Post-Acute Care/Long-Term Care (PAC/LTC) Programs
 - Measures Proposed for Multiple Programs
- Discussion of MAP Health Equity Review Process
- Opportunity for Public Comment
- Next Steps and Closing Comments
- Adjourn

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Welcoming Remarks from NQF Leadership



Kathleen Giblin, RN
Senior Vice President, Emerging Initiatives
National Quality Forum

Welcoming Remarks from Advisory Group Co-Chairs



Rebekah Angove, PhD
Patient Advocate Foundation



Laurie Zephyrin, MD, MPH, MBA
Commonwealth Fund

Disclosures of Interest

- State your name, title, organization, brief bio, and acknowledge the disclosure(s) you listed in your DOI form if applicable
- Briefly note any of the following disclosures *relevant to the project*:
 - ▣ Engagement with project sponsors (*Centers for Medicare & Medicaid Services*)
 - ▣ Research funding, consulting/speaking fees, honoraria
 - ▣ Ownership interest
 - ▣ Relationships, activities, affiliations, or roles

Example: I'm Joan Smith, Chief Medical Officer of ABC Healthcare. I am also a Principal Investigator for a research project examining health disparities and health outcomes funded by XYZ Organization.

Health Equity Advisory Group Membership

Advisory Group Co-Chairs: Rebekah Angove, PhD / Laurie Zephyrin MD, MPH, MBA

Organizational Members (Voting)

- Aetna
- American Medical Association
- American Nurses Association
- American Society of Health-System Pharmacists
- America's Essential Hospitals
- Beth Israel Lahey Health
- Fenway Health
- IBM Watson Health
- Kentuckiana Health Collaborative
- National Committee for Quality Assurance
- National Health Law Program
- Patient Safety Action Network
- Planned Parenthood Federation of America
- The SCAN Foundation
- Vizient Inc.

Health Equity Advisory Group Membership (cont.)

Individual Subject Matter Experts (Voting)

- Emily Almeda-Lopez, MPP
- Susannah Bernheim, MD, MHS
- Damien Cabezas, MPH, MSW
- Mark Friedberg, MD, MPP
- Jeff Huebner, MD
- Gerald Nebeker, PhD, FAAIDD
- J. Nwando Olayiwola, MD, MPH, FAAFP
- Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM
- Cardinale Smith, MD, PhD
- Melony Sorbero, PhD, MPH
- Jason Suh, MD

Federal Government Liaisons (Nonvoting)

- Centers for Medicare & Medicaid Services (CMS)
 - CMS Office of Minority Health (OMH)
- Health Resources & Services Administration (HRSA)
- Office of National Coordinator for Health Information Technology (ONC)
- Veterans Health Administration (VHA)

MAP Health Equity Advisory Group Staff



**Chelsea
Lynch,**
MPH, MSN,
RN, CIC
Director



**Katie
Berryman,**
MPAP,
PMP,
Senior
Project
Manager



**Ivory
Harding,**
MS,
Manager



Amy Guo,
MS,
Manager



**Victoria
Freire,**
MPH,
CHES[®],
Analyst



**Joelencia
LeFlore,**
Coordinator

CMS Staff

- **Kimberly Rawlings**, Task Order Contracting Officer's Representative (TO COR)
- **Gequincia Polk**, Indefinite Delivery/Indefinite Quantity Contracting Officer's Representative (IDIQ COR)

CMS Welcoming Remarks

Measure Applications Partnership

Health Equity Advisory Group
December 2021

Purpose of the MAP

- The Measure Applications Partnership is a convened group of experts who provide recommendations to CMS about whether or not measures under consideration should be included in CMS value based programs.
- Multi-stakeholder group feedback on the MUC List is a statutory requirement.
- MAP makes recommendations but does not have final authority for decisions around CMS programs.
- However, all MAP recommendations are strongly considered and assist CMS in decisions about programs.
- Measure set review was new for MAP this year.

Health Equity Advisory Group of the MAP

- The Equity committee of the MAP considers all measures across all programs to ensure that measures are assessed through the lens of the special needs of safety net providers, disadvantaged patient populations, and other issues of equity. Considerations may include:
 - Risk adjustment
 - Appropriate measures to measure and report on disparities
 - Potential unintended consequence of measures specific to equity

CMS Key Focus Areas for Quality

- COVID-19 and the PHE
- Equity – Access, Outcomes, Referrals, Experience
- Maternal Health and Safety
- Mental Health
- Resiliency and Emergency Preparedness
- Safety – not just patient safety, but workforce safety
- Digital transformation
- Climate Change
- Value

Potential Future Initiatives to Support Equity

- Request for Information across most payment rules in 2020
- Sought comment on:
 - Data collection – including direct v. indirect
 - Use of imputation models
 - Stratification of data
 - Public reporting
 - Measures specific to equity including measures of SDoH

Summary

- Thank you for your contributions and your important voice for equity
- Thank you for your contributions and heroic efforts for the COVID-19 PHE
- Look forward to your comments and recommendations today on the measures moving forward
- Happy Holidays!

MAP Health Equity Advisory Group 2021 Pre-Rulemaking Activities

MAP Health Equity Advisory Group Charge

- Provide input on MUCs with a lens to measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Provide input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages

Health Equity Advisory Group Review of Measures Under Consideration

- The Health Equity Advisory Group will review the measures under consideration (MUC) list and provide the following feedback to the setting-specific Workgroups:
 - ▣ Relative priority in terms of advancing health equity for all
 - ▣ Data collection and/or reporting challenges regarding health disparities
 - ▣ Methodological problems of calculating performance measures adjusting for health disparities
 - ▣ Potential unintended consequences related to health disparities if the measure is included in specific programs
 - ▣ Gap areas in measurement relevant to health disparities and critical access hospitals for specific programs

Health Equity Advisory Group Feedback on Measures Under Consideration

Health Equity Advisory Group feedback will be provided to the setting-specific Workgroups through the following mechanisms:

- Preliminary analyses (PAs):
 - ▣ A qualitative summary of Health Equity Advisory Group's discussion of the MUCs
 - ▣ Polling results that quantify the Health Equity Advisory Group's perception of the potential impact on health disparities if the MUCs are included in specific programs
 - » Average polling results
- Health Equity Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December

Process for Today's Discussion

- **Step 1.** NQF staff describes the program in which the measure is being proposed
- **Step 2.** The lead discussants will summarize the measure and offer initial thoughts about inclusion of the measure into the program
- **Step 3.** Advisory Group discusses each measure and provides feedback on:
 - ▣ Relative priority in terms of advancing health equity for all
 - ▣ Data collection and/or reporting challenges regarding health disparities
 - ▣ Methodological problems of calculating performance measures adjusting for health disparities
 - ▣ Potential unintended consequences related to health disparities if the measure is included in specific programs

Process for Today's Discussion (cont.)

- **Step 4.** Advisory Group takes a poll on the potential impact on health disparities if the measure is included within a specific program
 - ▣ Range is 1-5, from negative impact (increasing disparities) to positive impact (reducing disparities)
- **Step 5.** Advisory Group discusses gap areas in measurement relevant to health disparities and critical access hospitals

Discussion Questions for Consideration

1. What aspects of health equity do you see this measure advancing (culture, access, outcomes, etc.)?
2. What social determinants of health should be considered related to this measure?
3. If the measure includes stratification or risk adjustment, are there any concerns about how the measure is stratified or risk adjusted from a health equity lens? What additional information would be beneficial to include? If the measure does not include stratification or risk adjustment, what information would be beneficial to include?
4. Would it be beneficial to provide stratification when providing performance feedback for this measure?
5. In what ways could the measure exacerbate disparities or have unintended consequences?
6. What measurement gaps related to health disparities and critical access hospitals are present in the program?

Measures Under Consideration 2021-2022

Measures Proposed for Clinician Programs

Part 1

MAP Clinician Workgroup Programs Under Discussion

Merit-based
Incentive Payment
System (MIPS)

Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
 - ▣ Pay-for-performance
 - ▣ There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
 - ▣ The MIPS performance categories and finalized 2021 weights:
 - » Quality (40%)
 - » Promoting Interoperability (25%)
 - » Improvement Activities (15%)
 - » Cost (20%)
 - » The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
 - ▣ Improve quality of patient care and outcomes for Medicare FFS.
 - ▣ Reward clinicians for innovative patient care.
 - ▣ Drive fundamental movement toward value in healthcare.

MUC2021-125: Psoriasis – Improvement in Patient-Reported Itch Severity

Description: The percentage of patients, aged 18 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Level of Analysis: Clinician

Risk Adjustment: None

Lead Discussants:

- ▣ Deidre Washington, National Committee for Quality Assurance
- ▣ Gerald Nebeker, Subject Matter Expert

MUC2021-135: Dermatitis – Improvement in Patient-Reported Itch Severity

Description: The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Level of Analysis: Clinician

Risk Adjustment: None

Lead Discussants:

- ▣ Deidre Washington, National Committee for Quality Assurance
- ▣ Gerald Nebeker, Subject Matter Expert

MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)

Description: The percentage of adult patients 18 years and older who had an elective primary total hip arthroplasty (THA) or total knee arthroplasty (TKA) during the performance period AND who completed both a pre- and post-surgical care goal achievement survey and demonstrated that 75% or more of the patient's expectations from surgery were met or exceeded.

The pre- and post-surgical surveys assess the patient's main goals and expectations (i.e., pain, physical function and quality of life) before surgery and the degree to which the expectations were met or exceeded after surgery. The measure will be reported as two risk-adjusted rates stratified by THA and TKA.

Level of Analysis: Clinician; Group

Risk Adjustment: Risk Adjusted; Stratified

Lead Discussants:

- ▣ Jeff Huebner, Subject Matter Expert
- ▣ J. Nwando Olayiwola, Subject Matter Expert

MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Description: The measure will estimate a clinician- and clinician group-level, risk-standardized improvement rate for patient-reported outcomes (PROs) following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age or older. Substantial clinical benefit (SCB) improvement will be measured by the change in score on the joint-specific patient-reported outcome measure (PROM) instruments, measuring hip or knee pain and functioning, from the preoperative assessment (data collected 90 to 0 days before surgery) to the postoperative assessment (data collected 300 to 425 days following surgery).

Level of Analysis: Clinician; Group

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Karthik Sivashanker, American Medical Association
- Susannah Bernheim, Subject Matter Expert

MUC2021-090: Kidney Health Evaluation

Description: Percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the 12-month measurement period

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- ▣ Jason Suh, Subject Matter Expert
- ▣ Emily Almeda-Lopez, Subject Matter Expert

MUC2021-127: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

Description: Percentage of patients aged 18 years and older with a diagnosis of CKD (Stages 1-5, not receiving Renal Replacement Therapy (RRT) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period.

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Susannah Bernheim, Subject Matter Expert
- Jeff Huebner, Subject Matter Expert

MUC2021-105: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

Description: Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- Irene Dankwa-Mullan, IBM Watson
- Joy Bland, Aetna

MUC2021-058: Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors

Description: Percentage of patients, aged 18 years and older, with a diagnosis of cancer, on immune checkpoint inhibitor therapy, and grade 2 or above diarrhea and/or grade 2 or above colitis, who have immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered.

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- ▣ Mark Friedberg, Subject Matter Expert
- ▣ Jason Suh, Subject Matter Expert

Lunch

Measures Proposed for PAC/LTC Programs

MAP PAC/LTC Workgroup Programs Under Discussion

Skilled Nursing
Facility Quality
Reporting Program
(SNF QRP)

Skilled Nursing
Facility Value-
Based Purchasing
(SNF VBP) Program

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Skilled nursing facilities (SNFs) that do not submit the required quality data will have their annual payment update reduced by 2%.
- **Program Goals:** Increase transparency so that patients are able to make informed choices.

MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel

Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

Level of Analysis: Facility

Risk Adjustment: None

Lead Discussants:

- ▣ Karthik Sivashanker, American Medical Association
- ▣ Stephanie Clouser, Kentuckiana Health Collaborative

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Program Type:** Value-Based Purchasing
- **Incentive Structure:** The SNF VBP Program awards incentive payments to SNFs based on a single all-cause readmission measure (SNF 30-Day All-Cause Readmission Measure; NQF #2510), as mandated by Protecting Access to Medicare Act (PAMA) of 2014. SNFs' performance period risk-standardized readmission rates are compared to their own past performance to calculate an improvement score and the National SNF performance during the baseline period to calculate an achievement score. The higher of the achievement and improvement scores becomes the SNF's performance score.
- SNFs with less than 25 eligible stays during the baseline period will not receive an improvement score. These SNFs will be scored on achievement only. SNFs with less than 25 eligible stays during the performance period will be "held harmless".
- **Program Goal:** Transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely volume, and linking payments to performance on a single readmission measure.

Protecting Access to Medicare Act (PAMA) and The Consolidated Appropriations Act of 2021

- The Protecting Access to Medicare Act (PAMA) of 2014 authorized the SNF VBP Program.
- Per PAMA, the all-cause measure will be replaced as soon as practicable with a potentially preventable readmission measure.
- CMS withholds 2% of SNF Medicare FFS payments to fund the Program, and 60% of these withheld funds are redistributed to SNFs in the form of incentive payments.
- The SNF VBP Program began awarding incentive payments to SNFs on October 1, 2018.
- The Consolidated Appropriations Act of 2021 allows the Secretary to apply up to 9 additional measures, which may include measures focusing on functional status, patient safety, care coordination, or patient experience for payments for services furnished on or after October 1, 2023.

MUC2021-095: CoreQ: Short Stay Discharge Measure

Description: The measure calculates the percentage of individuals discharged in a six month time period from a SNF, within 100 days of admission, who are satisfied (scoring a 3 or above on the survey).

Level of Analysis: Facility; Other: Resident

Risk Adjustment: None

Lead Discussants:

- ▣ Sarita Mohanty, The SCAN Foundation
- ▣ David Machledt, National Health Law Program

MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)

Description: This measure estimates the risk-adjusted rate of successful discharge to community from a SNF, with successful discharge to community including no unplanned rehospitalizations and no death in the 31 days following SNF discharge. The measure is calculated using the following formula: (risk-adjusted numerator/risk-adjusted denominator)*national observed rate. The fields below describe the adjusted numerator and denominator in more detail. The measure is calculated using two years of Medicare FFS claims data.

Level of Analysis: Facility; Other: Stay

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ Melony Sorbero, Subject Matter Expert
- ▣ Beth Godsey, Vizient

MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

Description: This measure estimates the risk-adjusted rate of healthcare-associated infections (HAIs) that are acquired during skilled nursing facility (SNF) care and result in hospitalizations. The measure is risk adjusted to “level the playing field” and to allow comparison of performance based on residents with similar characteristics between SNFs. The one-year measure is calculated using the following formula: (risk-adjusted numerator/risk-adjusted denominator)*national observed rate. It is important to recognize that HAIs in SNFs are not considered “never-events.” The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs when compared to their peers.

Level of Analysis: Facility; Other: Stay

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ Joy Bland, Aetna
- ▣ Alicia Cole, Patient Safety Action Network

MUC2021-137: Total Nursing Hours Per Resident Day

Description: Total nursing hours (RN + LPN + nurse aide hours) per resident day. The source for total nursing hours is CMS's Payroll-based Journal (PBJ) system. The denominator for the measure is a count of daily resident census derived from Minimum Data Set (MDS) resident assessments. The measure is case-mix adjusted based on the distribution of MDS assessments by Resource Utilization Groups, version IV (RUG-IV groups).

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ Roberta Waite, American Nurses Association
- ▣ Lenor Fernandez, Beth Israel Lahey Health

Measures Proposed for Multiple Programs

Part 1

MUC2021-136: Screening for Social Drivers of Health

Description: Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.

Level of Analysis: Clinician; Group; Facility; Other: Beneficiary, Population

Risk Adjustment: Stratified

Lead Discussants:

- Nneka Sederstrom, Subject Matter Expert
- J. Nwando Olayiwola, Subject Matter Expert

MUC2021-136: Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
 - ▣ Pay-for-performance
 - ▣ There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
 - ▣ The MIPS performance categories and finalized 2021 weights:
 - » Quality (40%)
 - » Promoting Interoperability (25%)
 - » Improvement Activities (15%)
 - » Cost (20%)
 - » The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
 - ▣ Improve quality of patient care and outcomes for Medicare FFS.
 - ▣ Reward clinicians for innovative patient care.
 - ▣ Drive fundamental movement toward value in healthcare.

MUC2021-136: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-134: Screen Positive Rate for Social Drivers of Health

Description: Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.

Level of Analysis: Clinician; Group; Facility; Other: Beneficiary, Population

Risk Adjustment: Stratified

Lead Discussants:

- Nneka Sederstrom, Subject Matter Expert
- J. Nwando Olayiwola, Subject Matter Expert

MUC2021-134: Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program
- **Incentive Structure:**
 - ▣ Pay-for-performance
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- **Program Goals:**
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- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-084: Hospital Harm – Opioid-Related Adverse Events

Description: This measure assesses the proportion of inpatient hospital encounters where patients ages 18 years of age or older have been administered an opioid medication, subsequently suffer the harm of an opioid-related adverse event and are administered an opioid antagonist (naloxone) within 12 hours. This measure excludes opioid antagonist (naloxone) administration occurring in the operating room setting.

Level of Analysis: Facility

Risk Adjustment: None

Lead Discussants:

- ▣ Damien Cabezas, Subject Matter Expert
- ▣ Deidre Washington, National Committee for Quality Assurance

MUC2021-084: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-084: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

Break

Measures Proposed for Clinician Programs

Part 2

MAP Clinician Workgroup Programs Under Discussion (cont.)

Medicare
Parts C&D
Star Ratings

Part C and D Star Ratings

- **Program Type:** Quality Payment Program and Public Reporting
- **Incentive Structure:**
 - ▣ Medicare Advantage: Public reporting and quality bonus payments (QBP)
 - ▣ Stand-alone Prescription Drug Plans: Public reporting
- **Program Goal:**
 - ▣ Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices
 - ▣ Incentivize high performing plans (Part C)

The April 2018 final rule (CMS-4282-F) initially codified the methodology for the Part C and Part D Star Ratings

MUC2021-053: Concurrent Use of Opioids and Benzodiazepines (COB)

Description: The percentage of Medicare Part D beneficiaries, 18 years or older with concurrent use of prescription opioids and benzodiazepines during the measurement period.

Level of Analysis: Health Plan

Risk Adjustment: None

Lead Discussants:

- ▣ Damien Cabezas, Subject Matter Expert
- ▣ Roberta Waite, American Nurses Association

MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

Description: The percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period.

Level of Analysis: Health Plan

Risk Adjustment: None

Lead Discussants:

- Lanita White, American Society of Health-System Pharmacists
- Sarita Mohanty, The SCAN Foundation

MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)

Description: The percentage of Medicare Part D beneficiaries 65 years of age or older, with concurrent use of 3 or more unique central-nervous system (CNS)-active medications during the measurement period.

Level of Analysis: Health Plan

Risk Adjustment: None

Lead Discussants:

- ▣ Sarita Mohanty, The SCAN Foundation
- ▣ Lanita White, American Society of Health-System Pharmacists

Measures Proposed for Hospital Programs

MAP Hospital Workgroup Programs Under Discussion

End-Stage Renal
Disease Quality
Incentive Program
(ESRD QIP)

Hospital Inpatient
Quality Reporting
Program (Hospital
IQR Program)

PPS-Exempt Cancer
Hospital Quality
Reporting (PCHQR)

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.
- **Program Goal:** Improve the quality of dialysis care and produce better outcomes for beneficiaries.

MUC2021-101: Standardized Readmission Ratio (SRR) for Dialysis Facilities

Description: The Standardized Readmission Ratio (SRR) for a dialysis facility is the ratio of the number of observed index discharges from acute care hospitals to that facility that resulted in an unplanned readmission to an acute care hospital within 4-30 days of discharge to the expected number of readmissions given the discharging hospitals and the characteristics of the patients and based on a national norm. Note that the measure is based on Medicare-covered dialysis patients.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ Stephanie Clouser, Kentuckiana Health Collaborative
- ▣ Lenor Fernandez, Beth Israel Lahey Health

Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-106: Hospital Commitment to Health Equity

Description: Among Medicare beneficiaries, racial and ethnic minority individuals, individuals with limited English proficiency or disabilities often receive lower quality of care and higher rates of readmission and complications than beneficiaries without these characteristics. Strong and consistent hospital leadership can be instrumental in setting specific, measurable, and attainable goals to advance equity priorities and improve care for all beneficiaries. This includes promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes, which are assessed in this measure.

Level of Analysis: Facility

Risk Adjustment: None

Lead Discussants:

- ▣ Lenor Fernandez, Beth Israel Lahey Health
- ▣ Emily Almeda-Lopez, Subject Matter Expert

MUC2021-122: Excess Days in Acute Care (EDAC) After Hospitalization For Acute Myocardial Infarction (AMI)

Description: This measure estimates days spent in acute care within 30 days of discharge from an inpatient hospitalization for AMI. This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm (PRA). Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of half-day increments.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ Kirsten Bibbins-Domingo, America's Essential Hospitals
- ▣ Mark Friedberg, Subject Matter Expert

MUC2021-120: Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty (THA/TKA)

Description: This measure estimates hospital-level, risk-standardized payments for an elective primary total THA/TKA episode of care, starting with an inpatient admission to a short-term acute care facility and extending 90 days post admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ David Machledt, National Health Law Program
- ▣ Kirsten Bibbins-Domingo, America's Essential Hospitals

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- **Program Type:** Quality Reporting Program
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

MUC2021-091: Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer

Description: Percentage of female patients aged 18 to 70 with stage I (T1c) – III HER-2 positive breast cancer for whom appropriate treatment is initiated

Level of Analysis: Clinician; Group

Risk Adjustment: None

Lead Discussants:

- ▣ Chris Grasso, Fenway Health
- ▣ Tala Mansi, Planned Parenthood Federation of America

Break

Measures Proposed for Multiple Programs

Part 2

MUC2021-118: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Description: The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to 90 days post-date of the index admission (the admission included in the measure cohort).

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Beth Godsey, Vizient
- Melony Sorbero, Subject Matter Expert

MUC2021-118: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-118: Hospital Value-Based Purchasing Program (VBP)

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2% of base operating diagnosis-related group (DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments.
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards.

MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital

Description: The measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital and assesses the cost to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during an MSPB Hospital episode, which is comprised of the periods 3-days prior to, during, and 30-days following a patient's hospital stay. The measure is not condition specific and uses standardized prices when measuring costs. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who were discharged between January 1 and December 1 in a calendar year from short-term acute hospitals paid under the Inpatient Prospective Payment System.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted; Stratified

Lead Discussants:

- ▣ Mark Friedberg, Subject Matter Expert
- ▣ Melony Sorbero, Subject Matter Expert

MUC2021-131: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-131: Hospital Value-Based Purchasing Program (VBP)

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2% of base operating diagnosis-related group (DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments.
- **Program Goal:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards.

MUC2021-104: Severe Obstetric Complications eCQM

Description: Proportion of patients with severe obstetric complications which occur during the inpatient delivery hospitalization.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted; Stratified

Lead Discussants:

- ▣ Tala Mansi, Planned Parenthood Federation of America
- ▣ Chris Grasso, Fenway Health

MUC2021-104: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-104: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure

Description: This measure tracks the development of new *Clostridioides difficile* (*C. difficile*) infection among patients already admitted to healthcare facilities, using algorithmic determinations from data sources widely available in electronic health records. This measure improves on the original measure by requiring both microbiologic evidence of *C. difficile* in stool and evidence of antimicrobial treatment.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- Irene Dankwa-Mullan, IBM Watson
- Susannah Bernheim, Subject Matter Expert

MUC2021-098: Proposed Programs

■ Hospital Programs

- ▣ Hospital-Acquired Condition Reduction Program
- ▣ Hospital Inpatient Quality Reporting Program
- ▣ Medicare Promoting Interoperability Program for Hospitals
- ▣ Prospective Payment System (PPS)-Exempt Cancer Hospitals Quality Reporting Program

■ PAC/LTC Programs

- ▣ Inpatient Rehabilitation Facility Quality Reporting Program
- ▣ Long-Term Care Hospital Quality Reporting Program
- ▣ Skilled Nursing Facility Quality Reporting Program

MUC2021-098: Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce hospital-acquired conditions (HACs) through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

MUC2021-098: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-098: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-098: PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- **Program Type:** Quality Reporting Program
- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.
- **Program Goal:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

MUC2021-098: Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** IRFs that fail to submit data will have their applicable IRF Prospective Payment System (PPS) payment update reduced by 2%.
- **Program Goal:** Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

MUC2021-098: Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Long-term care hospitals (LTCHs) that fail to submit data will have their applicable annual payment update (APU) reduced by 2%.
- **Program Goal:** Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).

MUC2021-098: Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** Skilled nursing facilities (SNFs) that do not submit the required quality data will have their annual payment update reduced by 2%.
- **Program Goals:** Increase transparency so that patients are able to make informed choices.

MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

Description: This measure tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records. This measure includes many healthcare-associated infections not currently under surveillance by the Center for Disease Control and Prevention (CDC)'s National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.

Level of Analysis: Facility

Risk Adjustment: Risk Adjusted

Lead Discussants:

- ▣ Alicia Cole, Patient Safety Action Network
- ▣ Beth Godsey, Vizient

MUC2021-100: Proposed Programs

- **Hospital Programs**

- ▣ Hospital-Acquired Condition Reduction Program
- ▣ Hospital Inpatient Quality Reporting Program
- ▣ Medicare Promoting Interoperability Program for Hospitals
- ▣ Prospective Payment System (PPS)-Exempt Cancer Hospitals Quality Reporting Program

MUC2021-100: Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goal:** Encourage hospitals to reduce hospital-acquired conditions (HACs) through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

MUC2021-100: Hospital Inpatient Quality Reporting Program (IQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update.
- **Program Goal:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

MUC2021-100: Medicare Promoting Interoperability Program for Hospitals

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goal:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

MUC2021-100: PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

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- **Incentive Structure:** PCHQR is a voluntary quality reporting program. Data are published on Hospital Compare.
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Discussion of MAP Health Equity Review Process

Feedback on MAP Health Equity Review Process

- What worked well during the Advisory Group's review of the MUC list?
- What would help the Advisory Group's review process be even better?
- Do you have any suggested improvements to the criteria used to review the MUCs, meeting processes and logistics, etc.?

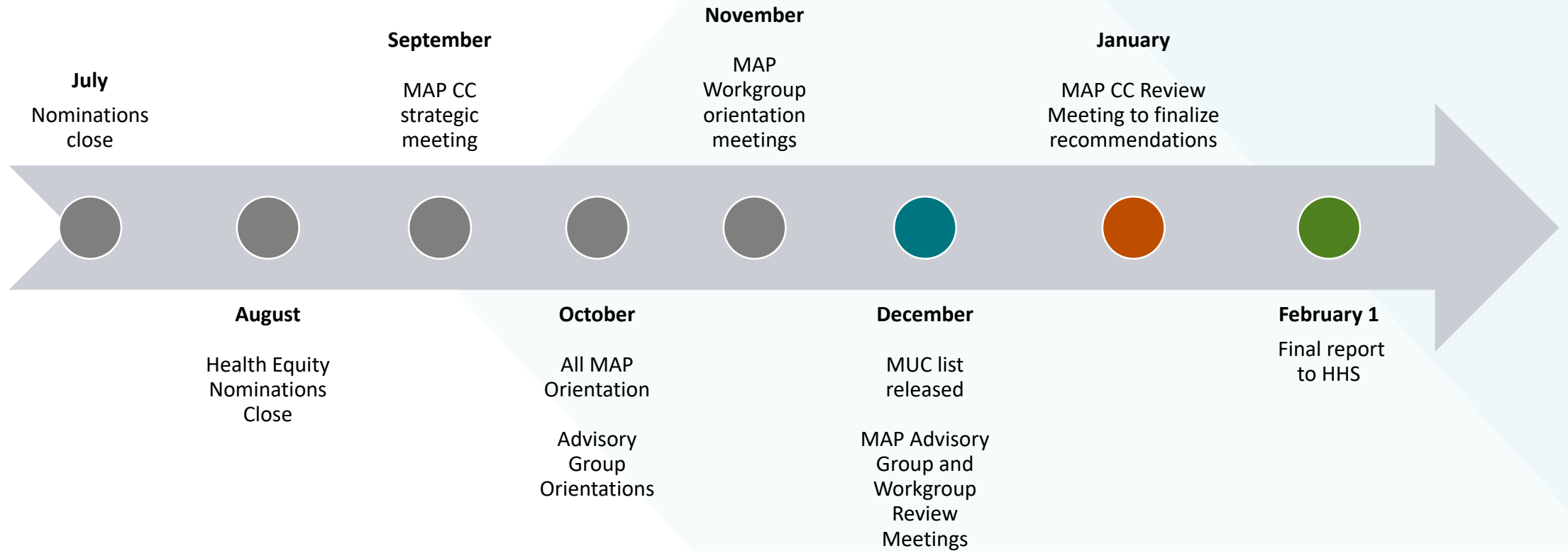
Public and Member Comment

Next Steps

Timeline of Upcoming Activities

- **Public Comment Period 1** – December 3, 2021 – December 9, 2021
- **Workgroup Review Meetings**
 - ▣ Clinician Workgroup – **December 14**
 - ▣ Hospital Workgroup – **December 15**
 - ▣ Post-Acute/Long-Term Care (PAC/LTC) Workgroup – **December 16**
 - ▣ Coordinating Committee – **January 19, 2022**
- **Public Comment Period 2** – December 30, 2021 – January 13, 2022
- **Final recommendations to CMS** – by February 1st, 2022

Timeline of Upcoming Activities (cont.)



Contact Information

- Project page:
 - [https://www.qualityforum.org/MAP Health Equity Advisory Group.aspx](https://www.qualityforum.org/MAP_Health_Equity_Advisory_Group.aspx)
- Advisory Group SharePoint site:
 - <https://share.qualityforum.org/portfolio/MAPHealthEquityAdvisoryGroup/SitePages/Home.aspx>
- Email:
 - MAPHealthEquity@qualityforum.org

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